		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045153

Facility Name: SYCAMORE HEALTHCARE CENTRE

Address: 720 SYCAMORE (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-4397994

Date of Initial License for Current Owners: 10/18/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3	111	Intermediate (ICF)	111	40,515	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	205	TOTALS	205	74,825	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,822	959	5,983	11,764	8
9	SNF/PED					9
10	ICF	37,599	6,210		43,809	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,421	7,169	5,983	55,573	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.27%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/18/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/18/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 94 and days of care provided 5,983

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	179,029	16,628	8,120	203,777		203,777		203,777			1
2	Food Purchase		218,230		218,230		218,230	(1,515)	216,715			2
3	Housekeeping	127,565	30,124		157,689		157,689		157,689			3
4	Laundry	97,817	16,255	500	114,572		114,572		114,572			4
5	Heat and Other Utilities			121,232	121,232		121,232	294	121,526			5
6	Maintenance	82,932	9,073	45,615	137,620		137,620	5,295	142,915			6
7	Other (specify):*			23,789	23,789		23,789	32	23,821			7
8	**TOTAL General Services**	487,343	290,310	199,256	976,909		976,909	4,106	981,015			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,718,331	91,652	11,148	1,821,131		1,821,131		1,821,131			10
10a	Therapy	158,616		1,782	160,398		160,398		160,398			10a
11	Activities	94,333	4,866	4,326	103,525		103,525		103,525			11
12	Social Services			3,046	3,046		3,046		3,046			12
13	Nurse Aide Training											13
14	Program Transportation			313	313		313		313			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,971,280	96,518	32,615	2,100,413		2,100,413		2,100,413			16
	C. General Administration											
17	Administrative	70,833		54,750	125,583		125,583	17,532	143,115			17
18	Directors Fees											18
19	Professional Services			39,327	39,327		39,327	13,587	52,914			19
20	Dues, Fees, Subscriptions & Promotions			41,838	41,838		41,838	(27,501)	14,337			20
21	Clerical & General Office Expenses	60,290	24,390	31,355	116,035		116,035	11,106	127,141			21
22	Employee Benefits & Payroll Taxes			372,680	372,680		372,680	(7,380)	365,300			22
23	Inservice Training & Education			4,560	4,560		4,560	31	4,591			23
24	Travel and Seminar			3,789	3,789		3,789		3,789			24
25	Other Admin. Staff Transportation			9,954	9,954		9,954	583	10,537			25
26	Insurance-Prop.Liab.Malpractice			108,187	108,187		108,187	745	108,932			26
27	Other (specify):*			83,813	83,813		83,813	(78,700)	5,113			27
28	**TOTAL General Administration**	131,123	24,390	750,253	905,766		905,766	(69,997)	835,769			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,589,746	411,218	982,124	3,983,088		3,983,088	(65,891)	3,917,197			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SYCAMORE HEALTHCARE CENTRE #0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,120	
	REPAIRS & MAINTENANCE		0	
			0	8,120
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		500	
			0	500
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,632	
	ELECTRICITY		69,267	
	WATER		18,023	
	CABLE TV - LOBBY		10,310	
			0	121,232
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		839	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		12,293	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		16,601	
	ELEVATOR MAINTENANCE & REPAIR		7,759	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6,568	
	FIRE SERVICE		1,555	
			0	
			0	
			0	45,615
7	**OTHER**			
	SCAVENGER		14,759	
	SECURITY SERVICE		9,030	23,789
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,250	
	PHARMACY CONSULTANT	XVIII B 39-2	3,648	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	5,250	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	11,148
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,633	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	149	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,782
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,326	
			0	4,326
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		105	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,941	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,046
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE **#0045153** **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		313	313
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	54,750	54,750
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,940	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	25,387	
			0	39,327
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24,518	
	EMPLOYEE WANT ADS	XIX F	5,481	
	CONTRIBUTIONS	VI 20 XIX F	300	
	DUES & SUBSCRIPTIONS	XIX F	7,416	
	LICENSES & PERMITS	XIX F	953	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	661	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,359	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	41,838
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		143	
	EQUIPMENT REPAIR & MAINTENANCE		4,374	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	15,084	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,754	
	MESSENGER SERVICE		0	
			0	31,355

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	198,116	
	UNEMPLOYMENT COMPENSATION	XIX D	30,912	
	WORKERS COMPENSATION INSURANCI	XIX D	82,624	
	HOSPITALIZATION INSURANCE	XIX D	44,076	
	EMPLOYEE BENEFITS - OTHER	XIX D	16,952	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	372,680
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,560	4,560
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	3,789	
			0	
			0	3,789
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,954	9,954
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		108,187	108,187
27	**OTHER**			
	BAD DEBTS	VI 24	83,813	
			0	83,813

GRAND TOTAL COLUMN 3 OTHER 982,124

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE #0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			69,791	69,791		69,791	98,723	168,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,408	63,408		63,408	305,250	368,658			32
33	Real Estate Taxes			35,212	35,212		35,212	1,518	36,730			33
34	Rent-Facility & Grounds			477,106	477,106		477,106	(477,106)				34
35	Rent-Equipment & Vehicles			24,949	24,949		24,949	4,309	29,258			35
36	Other (specify):* SEE SCHEDULE			15,266	15,266		15,266	(8,034)	7,232			36
37	**TOTAL Ownership**			685,732	685,732		685,732	(75,340)	610,392			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,476	258,470	384,946		384,946		384,946			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,237	112,237		112,237		112,237			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		126,476	370,707	497,183		497,183		497,183			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,589,746	537,694	2,038,563	5,166,003		5,166,003	(141,231)	5,024,772			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(37,124)	30		9
10	Interest and Other Investment Income	(51,175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,515)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(15,084)	21		18
19	Entertainment		20		19
20	Contributions	(2,659)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(83,813)	27		24
25	Fund Raising, Advertising and Promotional	(24,518)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(661)	20		28
29	Other-Attach Schedule	(4,488)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (221,187)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,956		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,956		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (141,231)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SYCAMORE HEALTHCARE CENTRE

ID# 0045153

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2,892	6	1
2	APARTMENT RENTAL	(7,380)	22	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,488)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,515)	0	0	0	0	0	0	0	0	0	0	(1,515)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	294	0	0	0	0	0	0	0	294	5
6	Maintenance	2,892	0	1,933	470	0	0	0	0	0	0	0	5,295	6
7	Other (specify):*	0	0	32	0	0	0	0	0	0	0	0	32	7
8	**TOTAL General Services**	1,377	0	1,965	764	0	0	0	0	0	0	0	4,106	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	11,620	5,912	0	0	0	0	0	0	0	0	17,532	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	150	7,087	125	6,225	0	0	0	0	0	0	13,587	19
20	Fees, Subscriptions & Promotions	(27,988)	0	487	0	0	0	0	0	0	0	0	(27,501)	20
21	Clerical & General Office Expenses	(15,084)	6,196	19,935	59	0	0	0	0	0	0	0	11,106	21
22	Employee Benefits & Payroll Taxes	(7,380)	0	0	0	0	0	0	0	0	0	0	(7,380)	22
23	Inservice Training & Education	0	0	31	0	0	0	0	0	0	0	0	31	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	179	404	0	0	0	0	0	0	0	0	583	25
26	Insurance-Prop.Liab.Malpractice	0	139	547	59	0	0	0	0	0	0	0	745	26
27	Other (specify):*	(83,813)	1,975	3,138	0	0	0	0	0	0	0	0	(78,700)	27
28	**TOTAL General Administration**	(134,265)	20,259	37,541	243	6,225	0	0	0	0	0	0	(69,997)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,888)	20,259	39,506	1,007	6,225	0	0	0	0	0	0	(65,891)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(37,124)	0	215	792	134,840	0	0	0	0	0	0	98,723	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,175)	0	0	1,220	355,205	0	0	0	0	0	0	305,250	32
33	Real Estate Taxes	0	0	0	1,518	0	0	0	0	0	0	0	1,518	33
34	Rent-Facility & Grounds	0	0	0	0	(477,106)	0	0	0	0	0	0	(477,106)	34
35	Rent-Equipment & Vehicles	0	862	3,373	74	0	0	0	0	0	0	0	4,309	35
36	Other (specify):*	0	0	0	(8,034)	0	0	0	0	0	0	0	(8,034)	36
37	**TOTAL Ownership**	(88,299)	862	3,588	(4,430)	12,939	0	0	0	0	0	0	(75,340)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(221,187)	21,121	43,094	(3,423)	19,164	0	0	0	0	0	0	(141,231)	45

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	75			EMI ENTERPRISES	LINCOLNWOOD	CONSULTING
DANIEL WEISS	25			EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
		SEE ATTACHED LIST		IME REALTY CORP	LINCOLNWOOD	OFFICE RENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$	EMI ENTERPRISES		$	$	1
2	V	17	OFFICERS SALARIES				11,620	11,620	2
3	V	19	ACCOUNTING FEES				150	150	3
4	V	21	TOTAL OFFICE				6,196	6,196	4
5	V	25	TRANSPPORTATION				179	179	5
6	V	26	INSURANCE				139	139	6
7	V	27	EMPLOYEE BENEFITS				1,975	1,975	7
8	V	35	AUTO LEASE				862	862	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 21,121	$ * 21,121	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$	EKS MANAGEMENT		$	$	15
16	V								16
17	V	6	PAINTERS SALARIES				1,933	1,933	17
18	V	7	SCAVENGER				32	32	18
19	V	17	C F O SALARY				5,912	5,912	19
20	V	19	PROFESSIONAL FEES				7,087	7,087	20
21	V	20	WANT ADS/ BACK GR CKS				487	487	21
22	V	21	OFFICE EXPENSE				19,935	19,935	22
23	V	23	SEMINARS				31	31	23
24	V	25	TRANSPORTATION				404	404	24
25	V	26	INSURANCE				547	547	25
26	V	27	EMPLOYEE BENEFITS				3,138	3,138	26
27	V	30	DEPRECIATION				215	215	27
28	V	35	EQUIPMENT RENT				3,373	3,373	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 43,094	$ * 43,094	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 8,034			$	$ (8,034)	15
16	V								16
17	V	5	UTILITIES				294	294	17
18	V	6	REPAIRS / MAINTENANCE				470	470	18
19	V	19	PROFEESIONAL FEES				125	125	19
20	V	21	OFFICE EXPENSE				59	59	20
21	V	26	INSURANCE				59	59	21
22	V	30	DEPRECIATION				792	792	22
23	V	32	INTEREST				1,220	1,220	23
24	V	33	R/E TAX				1,518	1,518	24
25	V	35	STORAGE FEES				74	74	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,034			$ 4,611	$ * (3,423)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 477,106	QUINCY EXTENDED CARE LIMITED PARTNERSHIP	100.00%	$	$ (477,106)	15
16	V	30	DEPRECIATION-SL				134,840	134,840	16
17	V	32	INTEREST				355,205	355,205	17
18	V	19	ACCOUNTING FEES				6,225	6,225	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 477,106			$ 496,270	$ * 19,164	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	MEMBER	Administration	75.00	See Attached			Salary	$ 11,620	17-8	1
2	DANIEL WEISS	MEMBER	Administration	25.00	See Attached			Salary	54,750	17-8	2
3	AVRUM WEINFELD	CFO			See Attached			Salary	5,912	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,282		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	884,739	14	$ 185,000	$ 185,000	55,573	$ 11,620	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381		55,573	150	2
3	21	TOTAL OFFICE	PATIENT DAYS	884,739	14	98,637	76,255	55,573	6,196	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845		55,573	179	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209		55,573	139	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442		55,573	1,975	6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730		55,573	862	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 336,244	$ 261,255		$ 21,121	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC
Street Address: 6865 N. LINCON
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARY	PATIENT DAYS	884,739	14	$ 30,769	$ 30,769	55,573	$ 1,933	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510		55,573	32	2
3	17	C F O SALARY	PATIENT DAYS	884,739	14	94,128	94,128	55,573	5,912	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	83,281	55,573	7,087	4
5	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	884,739	14	7,759		55,573	487	5
6	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	317,364	228,335	55,573	19,935	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490		55,573	31	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427		55,573	404	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715		55,573	547	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951		55,573	3,138	10
11	30	DEPRECIATION	PATIENT DAYS	884,739	14	3,418		55,573	215	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	884,739	14	53,700		55,573	3,373	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 686,066	$ 436,513		$ 43,094	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	303,433	15	$ 11,111	$	8,034	$ 294	1
2	6	REPAIRS / MAINTENANCE	INCOME	303,433	15	17,749		8,034	470	2
3	19	PROFESSIONAL FEES	INCOME	303,433	15	4,725		8,034	125	3
4	21	OFFICE EXPENSE	INCOME	303,433	15	2,247		8,034	59	4
5	26	INSURANCE	INCOME	303,433	15	2,237		8,034	59	5
6	30	DEPRECIATION (SL)	INCOME	303,433	15	29,895		8,034	792	6
7	32	INTEREST	INCOME	303,433	15	46,095		8,034	1,220	7
8	33	REAL ESTATE TAX	INCOME	303,433	15	57,331		8,034	1,518	8
9	35	STORAGE FEES	INCOME	303,433	15	2,800		8,034	74	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,190	$		$ 4,611	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUICY EXTENDED CARE LTD. PTSHP
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD,IL 60712
Phone Number: (847)674-5795
Fax Number: (847)674-6794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION-SL	DIRECT	1	1	$ 134,840	$	1	$ 134,840	1
2	32	INTEREST	DIRECT	1	1	355,205		1	355,205	2
3	19	ACCOUNTING FEES	DIRECT	1	1	6,225		1	6,225	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 496,270	$		$ 496,270	25

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Quincy Care Partnership	X			$9,003.00	1/01/02	$ 1,157,443	$ 1,046,355	12/1/2016	0.0475	$ 51,175	1
2												2
3												3
4	RELATED PARTY - LASALLE		X	MORTGAGE	$36,140.34	12/5/01	5,000,000	4,853,313	8/18/06	0.0725	355,205	4
5	RELATED PARTY - ALLOCATION										1,220	5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL		10/01/02					11,951	6
7			X	INSURANCE POLICY							282	7
8												8
9	TOTAL Facility Related				$45,143.34		$ 6,157,443	$ 5,899,668			$ 419,833	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,157,443	$ 5,899,668			$ 419,833	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 33,328	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 34,270	2
3. Under or (over) accrual (line 2 minus line 1).		$ 942	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,270	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 35,212	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000	6,669	10
2001	33,328	11
2002	34,270	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SYCAMORE HEALTHCARE CENTRE COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0045153

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-4-1476-000-00	NURSING HOME	$ 34,270.14	$ 34,270.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,270.14	$ 34,270.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,691 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1997	$ 452,195	1
2					2
3	TOTALS			$ 452,195	3

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY		1997		$ 3,659,759	$ 93,840	39	$ 93,840	$	$ 645,150	4
5											5
6											6
7	RELATED PARTY					775		775			7
8											8
	Improvement Type**										
9	WALK IN COOLER			2001	18,153	660	27.5	660		1,574	9
10	SMOKE DAMPERS			2002	3,622	132	27.5	132		203	10
11	TILING			2002	8,511	309	27.5	309		477	11
12	FURNISHING - CARPETING			2002	10,276	2,302	5	2,055	(247)	4,110	12
13	FURNISHING - DRAPES			2002	20,425	4,575	5	4,085	(490)	8,170	13
14	FURNISHING - WALLPAPER			2002	6,185	1,385	5	1,237	(148)	2,474	14
15	FURNISHING - WINDOW & DOOR TREATMENTS			2003	21,042	11,047	5	2,209	(8,838)	2,209	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,747,973	$ 115,025		$ 105,302	$ (9,723)	$ 664,367	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 210,032	$ 44,780	$ 21,002	$ (23,778)	10 YRS	$ 36,741	71
72	Current Year Purchases	7,551	4,025	378	(3,647)	10 YRS	378	72
73	Fully Depreciated Assets							73
74	RELATED PARTIES	410,000	41,232	41,232		10 YRS	82,000	74
75	TOTALS	$ 627,583	$ 90,037	$ 62,612	$ (27,425)		$ 119,119	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		USED VAN	2001	$ 3,000	$ 576	$ 600	$ 24	5 YRS	$ 1,800	76
77										77
78										78
79										79
80	TOTALS			$ 3,000	$ 576	$ 600	$ 24		$ 1,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,830,751	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 205,638	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,514	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,124)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 785,286	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: QUINCY EXTENDED CARE LIMITED PARTNERSHIP

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		205	10/18/00	$ 477,106	20		3
4	Additions							4
5								5
6								6
7	TOTAL		205		$ 477,106 **			7

10. Effective dates of current rental agreement:
Beginning 10/18/00
Ending 10/18/20

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 477,106
13.	/2005	$ 477,106
14.	/2006	$ 477,106

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 11,160 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		1999 FORD XLT	$ 450.00	$ 6,742	17
18		2003 JEEP GR CHEROKEE	522.00	5,269	18
19		2004 FORD WAGON	785.00	1,778	19
20					20
21	TOTAL		$ #######	$ 13,789	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 80,899	$		$ 80,899	1
2	Licensed Speech and Language Development Therapist		hrs			12,316			12,316	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			165,255			165,255	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				88,927		88,927	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): supplies & lab						37,549		37,549	13
14	TOTAL			$		$ 258,470	$ 126,476		$ 384,946	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 254,193	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	648,056		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,934		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow Deposit	39,732		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,018,915	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	30,286		15
16	Equipment, at Historical Cost	307,437		16
17	Accumulated Depreciation (book methods)	(215,743)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 121,980	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,140,895	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,423	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,398		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,487		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,270		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 315,578	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO QUINCY EXT. CARE PTNR	1,046,355		43
44	DUE TO MEMBERS	688,189		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,734,544	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,050,122	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (909,227)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,140,895	$	48

*(See instructions.)

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,290,372)	1
2	Restatements (describe):		2
3	RESTATEMENT OF CAPITAL	60,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,230,372)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	321,145	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 321,145	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (909,227)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,328,006	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,328,006	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	159,142	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 159,142	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,487,148	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	976,909	31
32	Health Care	2,100,413	32
33	General Administration	905,766	33
	B. Capital Expense		
34	Ownership	685,732	34
	C. Ancillary Expense		
35	Special Cost Centers	384,946	35
36	Provider Participation Fee	112,237	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,166,003	40
41	**Income before Income Taxes (line 30 minus line 40)****	321,145	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 321,145	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,775	1,790	$ 35,893	$ 20.05	1
2	Assistant Director of Nursing	2,081	2,241	37,985	16.95	2
3	Registered Nurses	7,010	7,356	117,915	16.03	3
4	Licensed Practical Nurses	42,250	43,818	607,195	13.86	4
5	Nurse Aides & Orderlies	90,903	97,765	794,305	8.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,522	15,720	158,616	10.09	8
9	Activity Director					9
10	Activity Assistants	10,565	11,121	94,333	8.48	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,082	2,124	33,585	15.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,484	20,194	145,444	7.20	15
16	Dishwashers					16
17	Maintenance Workers	5,890	6,315	82,932	13.13	17
18	Housekeepers	17,272	17,937	127,565	7.11	18
19	Laundry	10,807	11,329	97,817	8.63	19
20	Administrator	2,180	2,329	70,833	30.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,213	5,640	60,290	10.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,824	6,214	54,377	8.75	31
32	Other Health C: QA & nrsg adm	4,246	4,713	70,661	14.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,104	256,606	$ 2,589,746 *	$ 10.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 8,120	1-3	35
36	Medical Director	MONTHLY	12,000	9-3	36
37	Medical Records Consultant	MONTHLY	2,250	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	3,648	10-3	39
40	Physical Therapy Consultant	MONTHLY	1,633	10a-3	40
41	Occupational Therapy Consultant	MONTHLY	149	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	4,326	11-3	44
45	Social Service Consultant	MONTHLY	2,941	12-3	45
46	Other(specify) Psychiatric conslt	MONTHLY	5,250	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,317		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PHIL PENNINGTON	ADMIN	0	$ 12,500
VIOLA HUSKEY	ADMIN	0	58,333
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,833

B. Administrative - Other

Description	Amount
DANIEL WEISS	$ 54,750
TOTAL (agree to Schedule V, line 17, col. 3)	$ 54,750
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADAMS	DATA PROCESSING	$ 596
ALPHA DATA SERVICE	DATA PROCESSING	4,845
HEALTH DATA SYSTEM	DATA PROCESSING	3,549
LTC	DATA PROCESSING	1,320
MAXXSOURCE	DATA PROCESSING	1,230
WESMONT	DATA PROCESSING	2,400
KRUPNICK BOKOR	ACCOUNTING	11,100
LAWRENCE SCHWARTZ	LEGAL	540
SCHNACK LAW OFFICES	LEGAL	500
WINSTON & STRAWN	LEGAL	4,922
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	3,075
RICHARD PEELO	MEDICARE CONSULTANT	5,250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 39,327

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 82,624
Unemployment Compensation Insurance		30,912
FICA Taxes		198,116
Employee Health Insurance		44,076
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		16,952
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
EMPLOYEE BENEFITS-OTHER		(7,380)
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,481
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	25,179
TRUST/FRANCHISE/CONTRIB/ETC	2,809
LICENSES & PERMITS	753
DUES & SUBSCRIPTIONS	7,416
MGMT CO ALLOCATION	487
TRUST/FRANCHISE/CONTRIB/ETC	(2,809)
Less: Public Relations Expense	(0)
Non-allowable advertising	(24,518)
Yellow page advertising	(661)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,337

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,789
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,789

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	6/01	$ 947	3 YRS	$	$ 157	$ 316	$ 316	$ 158	$	$	$	$
2	PAINTING/DECORATIN	2002	7,728	3 YRS			1,288	2,576	2,576	1,288			
3													
4													
5													
6													
7													
8													
9													
10													
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16													
17													
18													
19													
20	TOTALS		$ 8,675		$	$ 157	$ 1,604	$ 2,892	$ 2,734	$ 1,288	$	$	$

Facility Name & ID Number SYCAMORE HEALTHCARE CENTRE # 0045153 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $7,066**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,547** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **112,237**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees